TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
NUEVA VIDA BEHAVIORAL HEALTH

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-16-3350-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
JULY 5, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The '97799-Functional Restoration Program Daily Progress Note' was submitted with each claim. This note indicated the topic that was discussed each hour and a brief explanation of the topic was included. The number of units/hours billed on this particular note is located and circled at the top right hand corner. There are 4 group topics on each Daily Progress Note…The 5th unit/hour is sometimes billed for a Case Management/Individual Therapy/Return to Work Plan. In addition, the units for physical therapy are provided on the 'Snowden Orthopedic and Occupational Rehabilitation' note."

Amount in Dispute: $1,800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "*Signature on documentation is illegible*… Texas Mutual relies on the above and all of the denial reasons noted on the EOBs and requests a resolution in its favor."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 25, 2016 January 26 2016	CPT Code 97799-CP (9 hours PER DAY x 2 = 18 hours) Chronic Pain Management Program	$1,800.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.10 sets out the billing provider's procedures.
3. 28 Texas Administrative Code §134.204, titled *Medical Fee Guideline for Workers' Compensation Specific*

Services, effective March 1, 2008, 33 TexReg 626, sets the reimbursement guidelines for the disputed service.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
    - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
    - CAC-16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
    - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
    - 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
    - 744-Does not meet the definition of case management per DWC rule 134.202 and/or 134.204.
    - 876-Required documentation missing or illegible. See rules 133.1; 133.210; 129.5; or 180.22.
    - 891-No additional payment after reconsideration.
    - 892-Denied in accordance with DWC rules and/or medical fee guideline including current CPT code and descriptions/instructions.

Issues

Is the requestor entitled to reimbursement chronic pain management program?

Findings

The requestor billed CPT code 97799-CP for a non-CARF accredited chronic pain management program.

28 Texas Administrative Code §134.204(h)(1)(B) states "If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

28 Texas Administrative Code §134.204(h)(5) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs:

(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

The division finds that the requestor billed the respondent CPT code 97799-CP for 18 hours. On the Table of Disputed Services the requestor is seeking 18 hours; however, in the packet there is a bill marked "Corrected Claim" for 17 hours. No EOBs or documentation was submitted to support the corrected claim was ever submitted to the insurance carrier; therefore, the division considers the dispute is over the bills and EOBs for 18 hours. A review of the submitted documentation does not support 18 hours of chronic pain management. As a result, no reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		3/8/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.